RHODE ISLAND DEPARTMENT OF HEATLH
VIOLENCE PREVENTION PROGRAM
STRATEGIC PLAN
PART ONE:
INTERNAL ASSESSMENT

JUNE 2000

TABLE OF CONTENTS

Executive Summary

INTRODUCTION

Violence prevention within the Rhode Island Department of Health (HEALTH) was prioritized in 1990 as a result of a community planning process initiated to guide the Injury Prevention Program. Since 1990, a number of violence prevention initiatives and activities have been implemented by HEALTH:

- In 1988, the Centers for Disease Control and Prevention (CDC) funded HEALTH with a comprehensive injury control capacity building grant focussing on all types of injury.

- In 1992, violence prevention was included in the HEALTH publication, "Healthy Rhode Islanders 2000" (**See Appendix F**), a community planning document which lays out the top 25 priority health objectives in RI for the 1990's. Two of these 25 objectives relate to violence prevention-- the reduction of homicides/assaults and suicide/suicide attempts.

- In 1994, CDC funded *Healthy Schools! Healthy Kids!* (HSHK), a collaboration between HEALTH and the RI Department of Education. HSHK is intended to strengthen health education, to prevent health-risk behaviors, to promote the integration of health and social services in schools, and to strengthen comprehensive school health programs at the state and local levels. Violence prevention is part of this effort.

- In 1995, the Intentional Injury Prevention Program at HEALTH received funds from CDC for the Violence Against Women Prevention Program (VAWPP). The VAWPP has focussed on activities related to domestic violence and teen dating violence, specifically, the enhanced surveillance (tracking trends) of domestic violence, including intimate partner violence (IPV) and sexual assault (SA), and the implementation of the RI Teen Dating Violence Prevention Program (RITDVPP).

- In 1999, with the assignment of a CDC Prevention Specialist, momentum was created for the establishment of the Violence Prevention Program (VPP). This program does not receive any other federal or state funding. Current resources include:

    - A violence prevention web site
    - A directory of community and school violence prevention interventions (created in conjunction with the Rhode Island Anti-Violence Coalition with support from the Attorney General's Office)
    - Violence prevention information (CDC/National publications, etc)
    - Access to national violence prevention experts in the field
    - Satellite broadcast technology
    - The Violence Against Women Surveillance System
    - Representation on the Rhode Island Anti-Violence Coalition
    - Membership in the Northeast Injury Prevention Network
    - Region I Suicide Data Book
    - Computer technology

While these current resources are valuable, the Violence Prevention Program hopes to expand its scope and its resources beyond those mentioned above, and beyond the prevention of Violence Against Women to include other areas of violence prioritized in "Healthy Rhode Islanders 2000" (homicides, assaults, suicides, and suicide attempts).

The following information was collected as part of the VPP's strategic planning process (**See Page 31**). The purpose of the internal assessment is to explore what resources currently exist within HEALTH including the *Healthy Schools! Healthy Kids!* initiative, and to understand how these resources may be utilized, directly or indirectly, to impact on violence prevention or its associated risk factors (**See Appendix A**). Compiling these available resources allows the VPP to efficiently and effectively coordinate these available resources and form lasting partnerships with our internal partners in HEALTH. This coordination and collaboration may ultimately allow for the VPP to secure funding for statewide violence prevention initiatives to reduce violence morbidity and mortality in Rhode Island.

METHODS

Survey Development/Instrument

Interview questions for the internal assessment were formulated by the Violence Prevention Program and then presented to HEALTH, and finally pilot tested and revised. Small changes were made several times throughout the internal assessment in order to expedite the interview process. The questionnaire is divided into eight sections: Mission and responsibilities, Constituencies, Written Materials and Publications, Partners, Working Groups, Internet Resources, Other Resources, and Other Contacts. In most sections, questions start out broadly asking about program activities and then become more focussed with the goal of finding out more specifically the nature of the resources that exist within HEALTH. For more background information see **Appendix B**.

Interview process

Between December 1999 and May 2000, 22 thirty-minute face-to-face interviews were conducted with HEALTH employees* and three Department of Education employees affiliated with *Healthy Schools! Healthy Kids!* Please note that the survey sample is made up of key informants and is not intended to be representative of HEALTH or HSHK. In order to be as inclusive as possible, an initial list of potential interview respondents was created by the Violence Prevention Program. Each respondent was then asked to provide additional names of people who could provide further input into this process. As many of the suggestions were followed through on, however, not all suggested people were interviewed since some were assessed to be duplicative (for a list of respondents and suggested participants see **Page 26**).

*Note: A face-to-face interview with the Coordinator of the Office of Minority Health within HEALTH was not possible. Information on this program was obtained instead via the Office of Minority Health web site and is included as part of the 23 HEALTH responses reported here.

Interviews with people from the *Healthy Schools! Healthy Kids!* followed an open-ended format as it was determined in mid-course that the questionnaire developed for HEALTH respondents was not sufficient for HSHK respondents (**See Part Two**).

Prior to each interview, respondents received a copy of the questionnaire (**See Appendix B**), its purpose, and other background material (**See Appendix A**) via email. After interviews were completed, results were recorded (**See Appendix C**) and summarized (**See Part One**). Not all of the questions were answered by all of the participants due to time constraints. Other missing responses in this compilation should be considered not applicable.

The following report contains three sections:

- Part One: Interview questions with an accompanying short summary of the responses provided (**See appendix C for individual responses**) by HEALTH respondents
- Part Two: Department of Education responses
- Part Three: Next steps in the strategic planning process

CONCLUSIONS

Based on the compiled internal assessment results (**See Parts One and Two and Appendices C, D, and E**), there are a number of conclusions that can be made. It is clear that while monetary resources are not in abundance, valuable in-kind (non-monetary) resources do exist. Because violence is an issue that effects all populations young and old, and without regard for race/ethnicity, gender, sexual-orientation, ability, or religion, the constituencies (populations) focussed on by different programs within HEALTH are, in many instances, the same potential constituency of an expanded violence prevention program. Additionally, the ways in which these groups are accessed by HEALTH programs suggest ways the Violence Prevention Program will also reach out to its constituency. More specifically:

Conclusion #1: A Receptive violence prevention audience exists.
There exist, according to the interviewees, invested groups of people ready to receive violence prevention messages. These people are policy makers, members of community coalitions, health care providers, leaders of community-based organizations, children, adults, members of the media, business people, clergy, leaders of voluntary organizations, professional organizations, groups that work with children, and people in other government agencies. Many of the groups and organizations work throughout Rhode Island and have broad networks of collaborators. For example, 35 substance abuse task forces are currently funded by the Tobacco Control Program. Each of these task forces, in turn, services a large number of people in the community. Far-reaching networks like these, in addition to the extensive constituencies reported in the assessment (**See page 10)** and the large numbers of funded groups, collaborations, and coalitions (**See pages 14-17**) offer numerous places in which to focus violence prevention efforts. At a minimum, there are opportunities for further discussion about potential violence prevention interventions/collaborations.

Conclusion #2: Vulnerable populations focussed on by programs in HEALTH are also at increased risk of violence.
Within HEALTH, programs try to meet the needs of various vulnerable (at-risk) populations including those whose health risk behaviors e.g. smoking, unsafe sex, etc. place them at-risk for negative health outcomes. Others are vulnerable due to having limited or no access to health care or insurance, e.g. poor women seeking mammography and cervical cancer screening. Many of the respondents mentioned a particular focus on children/teens (**See page 10**). According to the literature, there is a disproportionate impact of violence on young men, women and children, and the poor (Mercy, Rosenberg, Powell, Broome, and Roper, 1993). Therefore many of the populations being accessed by other programs within HEALTH are the same populations at-risk for violence. As described in conclusion one, HEALTH partners with numerous organizations and groups which, in turn, work with diverse groups of Rhode Islanders across the state. In addition, many of these Rhode Islanders are at-risk for violence and other negative health outcomes. These previously identified organizations and constituencies provide an opportunity to impact violence in Rhode Island.

Conclusion #3: Health Communication is a means of collaboration within HEALTH and among shared constituencies.
A useful means of disseminating health messages to the public is through various health communication media, including newsletters and brochures, the internet, policy briefings to key decision makers, and public education campaigns. Several programs stated that violence prevention messages would be appropriate material to include in their disseminated material. While coordination of this kind would take time and effort between programs, it appears a possible collaborative effort. Additionally, a number of programs are interested in creating mutual links between program web sites (**See page 23**). This would increase traffic flow on the HEALTH web site and would therefore benefit many programs.

Conclusion #4: Women and children/teens are an important potential focus for violence prevention efforts.
Most support for potential collaboration comes from programs within HEALTH that work with women and children/teens. Opportunities for reaching these groups were specifically noted by respondents from HIV, Women's Cancer Screening Program, Family Health, and *Healthy Schools! Healthy Kids!* The Department of Education and its Safe and Drug Free Schools program possesses data on the number of violent acts in school and about violence prevention programs implemented in schools. Looking at this information in combination with state data may show us where there is a need for further violence prevention programming.

Conclusion #5: Other resources that exist within HEALTH include personnel expertise and data.
HEALTH has ample expertise related to communication efforts and the media, data development, policy issues, and general public health information and skills. As a result there are many people who may provide brief consultation as needed during the VPP program's development. Additionally, HEALTH has several data sets including Behavior Risk Factor Surveillance System (BRFSS) data, Hospital Discharge Data (HDD), Mortality data, Emergency Medical Services (EMS) data, Family Health data, etc. that may provide useful to the VPP and its potential constituencies.

Conclusion #6: Prevention messages must address the entire Spectrum of Prevention
Based on public health prevention literature (Cohen and Swift, 1993; **see Appendix H for the Spectrum of Prevention**) and from the internal assessment results, it is clear that in order to make progress toward broad prevention goals, multiple interventions must be explored simultaneously. For example, many programs within HEALTH focus efforts at strengthening individual knowledge and skills, e.g. encouraging women's health screening. Other efforts provide community education, for example Family Health's Adolescent Campaign. Some groups like the Office of Primary Care focuses on educating providers, for example about diabetes. Worksite Wellness and facilities regulations work toward changing organizational practices impacting health outcomes. Finally, most offices/programs look to influence key policymakers. While the VPP does not currently have the resources to effect all of these levels, by collaborating with other HEALTH divisions and programs we can begin to make in-roads into each of these levels of prevention and thereby create the largest impact. If a choice among these levels is needed, impacting policy makers appears to be the most meaningful action.

Conclusion

Each of the resources identified in this assessment provides an opportunity for collaboration within HEALTH and the Department of Education that may not otherwise have been recognized or been able to be followed through on. If we primarily focus on impacting the same groups of people, with similar risk-factors, in groups all around RI, it makes the most sense to pool efforts inasmuch is possible. While categorical funding streams may not support this, with creativity and initiative it is feasible.

RECOMMENDATIONS

As mentioned above, the Spectrum of Prevention provides a useful model for focussing public health prevention initiatives. The following list includes the various levels in the Spectrum of Prevention and preliminary recommended action steps within each, to move violence prevention efforts forward in Rhode Island. These recommended actions stem in part, from the internal assessment conclusions/results and from actions taken by other HEALTH programs in the past. These are preliminary recommendations; before final recommendations can be made, input from our external partners will be obtained.

Influencing Policy and Legislation-

1. Collaborate with internal HEALTH partners working with youth and families to provide summary fact sheets about violence in Rhode Island among these populations.
HEALTH frequently provides fact sheets and briefings to legislators. Coordinated efforts on such briefings between programs would impact both internal and external working relationships. For example, coordinated written presentations of health issues effecting specific populations e.g. youth and families, presented to legislators could more efficiently highlight multiple needs of constituencies. Internally this approach would foster greater collaboration across division and programmatic lines while at the same time helping to preserve limited resources.

2. Create fact sheets or publicize current data sources of violence in Rhode Island.
Easily accessible violence prevention information should be provided to key policy makers including legislators. For example, in addition to legislative briefings, other violence prevention

messages e.g. fact sheets or sources of data (Healthy Rhode Islanders 2000) can be publicized via the web site to promote greater awareness among policy makers.

Changing Organizational Practices-

1) Partner with the Safety and Health Committee to implement a violence prevention policy for HEALTH.

Violence prevention should begin at HEALTH. In order to promote violence prevention and tolerance those promoting it must also practice it. The need to develop a policy for workplace violence prevention has been discussed at the Safety and Health Committee. It is recommended that development of this policy begin and upon completion disseminated to all HEALTH employees.

2) Lunchtime meetings for improved employee relations

Violence can be emotional and psychological as well as physical, therefore organizational practices should also promote a positive and healthy interpersonal environment. It is recommended that each office or program find a means of supporting staff on a regular basis in an informal setting. Monthly lunches are one suggestion. Having a time for both social gatherings as well as an opportunity to discuss employee relations may improve staff morale, productivity, and overall emotional health.

Fostering Coalitions/Networks-

1) Enhanced resource development for the Rhode Island Anti-Violence Coalition (RIAVC)

The Violence Prevention Program Manager currently sits as Co-chair on the RIAVC. This position serves as a link between HEALTH and the community. More resources to foster this linkage are recommended in order to maintain and enhance community relationships.

2) Brainstorm the need for a violence prevention advisory group in Rhode Island

Coalition development around the issue of violence may help bring greater awareness of the impact of violence to Rhode Islanders. Because the Rhode Island Anti-Violence Coalition exists it may not be necessary to form another community coalition. However, it is possible that a community-based advisory group may help guide violence prevention initiatives such as program development at HEALTH or advocacy in the community. This group could include members of HEALTH and other government agencies plus representation from community-based agencies, clergy, businesses, etc.

3) Create a violence prevention intra-departmental working group

Internally, as discussed in this assessment, many HEALTH programs work with populations impacted by violence. Because of this commonality, it makes sense to form a working group focussed on violence among our shared constituencies. Dialogue among internal HEALTH programs can foster lasting partnerships and linkages that are mutually beneficial.

4) Create web links between HEALTH programs and the Violence Prevention Program

Educating Providers-

1) Disseminate information to providers and students

Provider screening for violence may impact violence reporting and prevention. Information created for policy makers may be tailored to providers in the community via the VPP web site. In addition to written/internet materials, oral presentations to provider groups and students can help bring greater awareness to the impact of violence on patients and their families. Providers may also choose to be a part of an advisory group.

Promoting Community Education-

1) Media campaign

If monetary resources become available, promoting violence prevention most broadly can be achieved, in part, by means of a public education media campaign. This education could include press releases and other media events to promote violence prevention among all Rhode Islanders. Input from other people working in violence prevention and among HEALTH programs would be key to this effort.

2) Write articles in the Department Newsletter and other newsletters distributed to the public

Strengthening Individual Knowledge/Skills-

1) Collaboration with groups supporting individual positive health behaviors

Changes in violent behavior also must be promoted and taught on an individual and smaller group level. This may include collaborating with agencies which focus on conflict resolution and the building of tolerance among people.

For more information about the Violence Prevention Program or to view this document on-line, visit our web site at **http://www.health.state.ri.us/disprev/vpp/vpphome.htm** or call Deb Stone at 222-1394, ext. 134.

Part One
Department of Health Responses

INTERVIEW RESPONDENTS:

Summary: In order to be inclusive of the many diverse aspects of the work being done within HEALTH, all divisions were represented in the 23 Internal Assessment interviews, as shown.

Division	Office
Office of the Director	Community Affairs Health Policy & Planning Management Services
Disease Prevention and Control	AIDS/Sexually Transmitted Diseases Health Promotion and Chronic Disease Prevention Primary Care School and Worksite Health
Family Health	Adolescent and Young Adults Health Unit Children with Special Health Care Needs Women, Infants, and Children Program
Environmental Health	Occupational and Radiological Health Laboratories- Forensic Sciences Section
Health Services Regulations	Emergency Medical Services Facilities Regulations
Office of the State Medical Examiner	

MISSION AND RESPONSIBILITIES:

Questions about the mission of the programs/offices and about job responsibilities were asked in order to set the context for the rest of the survey questions. Question two provides a summary of all the individual program/division mission statements.

1. What program(s) within your division do you oversee or do you work for?

Summary: Over 30 programs were represented in the results outlined in this section. For particular programs represented **see Appendix C.**

2. What is the mission of your program (or division, if interviewee is responsible for more than one program)?

Summary:

• To prevent and control diseases in RI
• To provide health education to diverse populations in diverse settings
• To provide access to services for vulnerable populations and communities
• To regulate different types of health care facilities and services
• To provide expert opinion
• To impact health policy

CONSTITUENCIES

This question was asked in order to see which populations are being served the most and in what settings these groups are reached. This information in combination with violence epidemiology in RI and other HEALTH resources may help guide the development of future violence prevention interventions.

3. What population(s) does your work most directly impact and in what settings do you work with these populations? (gray boxes represent populations and settings served).

Summary: The following table shows the populations with whom survey respondents work with (or who their partners work with) and in what settings (shown by shaded boxes). Numbers represent how many respondents reported working with a particular population in a particular setting. Dark borders represent the most cited population worked with and the most cited setting. Again, these results represent only responses from participating programs.

Setting/ popula-tion	General RI population	People with special health needs	Men	Women	Adults (Men and women)	Children/ teens	Elderly	Specific ethnic groups	Un(der)in-sured	Other	**Total**
schools	1			1	2	8*		1	1		**14**
Prisons/ Jail			1	1	3	1					**6**
Hospitals Health Care	5*	3	3	5	5	8	1	2	4	1	**37**
Work-place	2*		3	2	5	2	1	1			**16**
CBO's	3*	1	2	2	3	4		4	2	1	**22**
Com-munity	6		1	1	2	3	1	2			**16**
Other	1	1	1	1	1	2		1		3	**11**
Total	**18**	**5**	**11**	**12**	**22**	**28**	**3**	**11**	**7**	**5**	

*These numbers include responses from two respondents who work for the same program.

Summary:Other populations and settings mentioned:

Other Populations	Other Settings
• Policy Makers • General Assembly • Physicians/Providers • Media • Health Insurance Providers • Law Enforcement • Business People • Child care providers • Employers • Newborns	• General Assembly • Government Agencies • Professional Organizations • Health professions training programs • Child Opportunity Zones (COZs) • Parent Networks • Tattoo Parlors • Homes • Voluntary Organizations • Churches • Businesses • Libraries

WRITTEN MATERIALS AND PUBLICATIONS

Questions about written materials were asked in order to determine the types of publications developed and distributed by HEALTH to its constituents. This set of questions also asked about the appropriateness of including violence prevention messages within these publications. Programs stating that violence messages would be appropriate offer a potential resource and opportunity for coordination among programs.

4. Does your program develop publications to be distributed to these constituencies?

Summary: Seventeen out of 23 respondents stated that publications are developed and distributed to their respective constituencies. Five respondents said that publications were not developed by their program/office. In these cases, information was often disseminated via internet or was received from federal or other agencies and distributed to the public.

a. What type of publication is distributed, to whom, and how often is it distributed?

Summary: There is no single type of publication developed and distributed most often. Similarly, the results show that publications are distributed to a wide range of people on a periodic basis.

Type of Publication	To Whom	How Often
• Newsletters • Brochures on specific health conditions • Brochures on specific health behaviors • Manuals • Licensure literature • Public education material • Policy Briefings • Journal articles • Data requests • Fact Sheets • Health information pertaining to minorities in RI • Healthy RI 2000 • Health data reports • State regulations • Protocols • General program information • Flyers	• Policy Makers • Legislators • Providers/Hospital personnel • People with special health needs • Funded groups • General RI Population • Prevention Professionals • Families • Schools • Community-Based Organizations • Employers • Professional groups • Program participants • Hospitals/ Hospices/Nursing Homes	• Quarterly • Monthly • Seasonally • Annually • On-going • Depends on what issues is being highlighted at any given time

b. Would violence prevention messages be appropriate material to include in these publications?

Summary: Thirteen out of the 17 respondents said that violence prevention messages would be appropriate to include in the above publications (within the actual text or as inserts). Publications that particularly focus on children, women, or the general RI population were specified as being appropriate for violence messages.

PARTNERS

The following table lists all of the partners with whom respondents stated that they either fund or work in collaboration or coalition with. This was of interest in order to get an idea of the breadth of partners HEALTH works with and to see where opportunities to focus violence prevention messages exist. Generic listings are in italics.

Name	**Funded Partner**	**Collaborator**	**Coalition**
Aging 2000 Coalition			X
AIDS Care Ocean State	X		
AIDS Project Rhode Island	X		
Allen AME Church	X		
American Cancer Society		X	
American Heart Association		X	
American Lung Association of RI	X		
Attorney General's Office		X	
Bradley Hospital for Child and Adolescent Mental Health		X	
Breast Cancer Coalition			X
Brown University		X	
Brown University Medical School Affinity Group			X
Businesses		X	
Caritas/Corkery House (Drug Abuse and Prevention Services)	X		
Community-based organizations	X	X	
Center for Hispanic Policy and Advocacy	X		
Children's Cabinet		X	
City of Pawtucket		X	
City of Providence	X	X	
Community-based hospitals		X	
Community Health Centers	X	X	
Contractors for BRFSS survey	X		
Contractors for Health Interview Survey	X		
Courts		X	
Child Opportunity Zones/ Family Centers			X
Cultural Coalition			X
Dawn for Children	X		
Department of Children, Youth, and Families		X	
Department of Corrections	X	X	
Department of Education		X	

Department of Elderly Affairs			
Department of Environmental Management		X	
Department of Health and Human Services		X	
Department of Labor		X	
Department of Mental Health Retardation and Hospitals		X	
Department of Transportation		X	
Duncan Avenue Arts	X		
Early Childhood Coalition			X
Elmwood Action			X
Employers		X	
Family planning clinics	X		
Family Resources, Inc.	X		
Family Voices	X		
Genesis Center	X	X	
Governor's Highway Safety Office		X	
Governor's Office		X	
Grassroots coalitions			X
Greater Elmwood Housing Association		X	
Hasbro Children's Hospital	X	X	
Healthy Mothers/Healthy Babies			X
HIV Prevention Educators			X
Homeless Commission on Housing			X
HSHK Ad Hoc Workgroups		X	
HSHK! Oral Health Initiative for School Aged Children			X
Hunger Coalition			X
Immunization Coalition			X
Indigent Drug Program			X
Initiatives for Human Development (Human Service Organization)	X		
Institute for International Sport	X		
Interagency Coordinating Council			X
International Institute	X	X	
James L Maher Center	X		
Jammat Housing Corporation	X		
John Hope Settlement House	X		
Loan Repayment Program	X		
Libraries		X	
MAP	X		
Media		X	
Media Consultants	X		
Meeting Street Center	X		

Memorial Hospital	X	X	
Minority Health Advisory Committee			X
Miriam Hospital	X	X	
National Association of State EMS Directors		X	
National Council of State EMS Training Coordinators			
New England Council for Emergency Medical Services		X	
New Visions of Newport County	X		
Oasis International (Human Services Center)	X		
Olney Street Baptist Church	X		
Oral Health Coordinating team (interdepartmental)			X
Pawtucket Family YMCA	X		
Police		X	
Policy Makers (General Assembly)		X	
Primary Care Physicians Advisory Committee			X
Professional Coalitions			X
Progresso Latino	X		
Project Hope	X		
Providence Center	X		
Providence Housing Authority	X		
Public Health Foundation		X	
Public Health Nursing	X		
Region 1 Women's Health Coalition			X
Rhode Island College		X	
Rhode Island Indian Council	X		
Rhodes Center at RI Hospital	X		
RI Anti-Violence Coalition			X
RI Association of Facilities for the Aged		X	
RI Association of Fire Chiefs		X	
RI Cancer Control Coalition			X
RI Dental Assistants Association		X	
RI Dental Association		X	X
RI Dental Hygiene Association			X
RIDHS Dental Advisory Committee			X
RI Foundation		X	
RI HIV Community Planning Group			X
RI Health Association		X	
RI Hospital		X	
RI Hospital Association		X	
RI Indian Council	X		

RI Medical Society		X	
RI Parks and Recreation		X	
RI Safety Association		X	
RI School for the Deaf	X		
RI Traffic Safety Coalition			X
RICover			X
RI Women's Commission			X
Rural Health Roundtable			X
Safe Kids/Safe Communities			X
School based health centers	X	X	
School Based Health Center Commission			X
Schools	X		
Socio-Economic Development Center	X		
Sojourner House	X		
South Providence Neighborhood Ministries	X		
State Professional Loan Repayment Board			X
Substance Abuse Prevention Task Forces	X		
Tobacco Control Coalition			X
Trade Groups		X	
Training School		X	
Traumatic Brain Association	X		
Traveler's Aid Society		X	
Trudeau Memorial Center (Developmentally Disabled Services)	X		
United Way		X	
Urban League	X		
Westminister Senior Center	X		
Women and Infants Hospital	X	X	
Women's Cancer Screening			X
Women's Commission			X
Youth advocacy groups	X		
Youth Connection			X
Youth in Action	X		
YWCA of Greater RI	X		

Questions 5-18 are asked in order to learn about the types of groups that HEALTH programs work with and the activities of these groups. It is likely that many of these groups are entrée points for violence prevention information. Additionally, understanding these activities leads to an understanding of resources provided by HEALTH.

5. What agencies, community organizations, or other groups do you fund? (If none, go to Q9) (See Pages 14-17)

Summary: Funding is provided by 5 of the offices/programs represented in this assessment to over 50 Community Based Organizations (CBO's), facilities, churches, and other agencies/schools and contractors.

6. Please briefly describe what this (these) group(s) are funded to do?

Summary: These groups are funded to provide a range of prevention services including:

• Conducting needs assessments
• Case management
• Community planning
• Providing community education
• Program development
• Providing clinical preventive services
• Advocating on behalf of particular communities
• Providing health education
• Program implementation
• Collecting data

7. What resources other than funding do you provide to this (these) group(s)? (i.e. publications, training, technical assistance, training, data analysis, etc.)

Summary: Other resources provided to these groups include:

• Training on service delivery techniques
• Capacity building
• Reference materials and guidelines
• Data summaries
• Technical assistance
• Networking opportunities
• Consultation and expertise
• Data evaluation

8. Would violence prevention messages be relevant to these groups or their constituencies? If so, which ones?

Summary: All of the offices/programs represented stated that violence prevention messages would be relevant to their funded groups and/or the constituencies of these groups.

9. What agencies or organizations do you collaborate with (see page 14-17)?

Summary: Over 50 government agencies, offices, voluntary organizations, and other public and private agencies collaborate with all of the programs/offices represented.

10. How often do you interact with these groups?

Summary: All collaborations are ongoing.

11. Please briefly describe the nature of this collaboration including any events or policy issues you plan or work on together?

Summary: In general, HEALTH collaborates with the above agencies pertaining to:

Advocacy/legislation	Surveillance activities
Prevention and health promotion activities	School-based activities
Health education	Children's issues
Public education campaigns	Quality improvement/assurance
Grant funding	Licensure and regulatory functions
Data development	Inter-agency forums
Data collection	Morbidity and mortality investigations
Publication dissemination	Compliance with regulations
Development of communication tools	Outreach
Development of training programs	Access to health services for vulnerable populations

12. What resources other than your participation do you provide to this (these) group(s) (i.e. publications, training, technical assistance, training, data analysis, etc.)?

Summary: Resources provided to these groups include the following:

Training	Continuing education
Technical assistance/consultation	Data
Publications	Public Health Perspective
Data analysis	Health Information
Human resources	Public Health strategies
Collaboration on events	Resource development
Networking	

13. Would violence prevention messages be relevant to these groups or their constituencies? If so, which ones?

Summary: Fourteen out of 20 respondents who reported collaborations said yes, that violence prevention messages would be relevant to groups they collaborate with and/or the constituencies of these groups.

14. What coalitions are you a part of (See pages 14-17)?

Summary: Over 30 coalitions were identified by 15 respondents.

15. How often do you interact with these groups?

Summary: All coalition work is ongoing

16. Please describe the nature of your involvement in these groups, including any events or policy issues you work on together?

Summary: Coalition work primarily revolves around the following issues:

• Advance recommendations
• Strategy development
• Media advocacy
• Development of publications
• Public Education
• Provider Education
• Gaps analysis
• Comprehensive planning efforts
• Minority health issues
• Outreach training
• Policy discussions
• Prevention programming
• Advisory function

17. What resources other than participation do you provide to this (these) group(s)? (i.e. publications, training, technical assistance, training, data analysis, etc.)?

Summary: Other resources provided to these coalitions include the following:

• Providing educational materials
• Organizing events
• Planning/buying media
• Participation in education subcommittee
• Training
• Providing technical assistance
• Data analysis
• Data collection
• Advocacy/Policy development
• Convening informant groups
• Policy analysis

18. Would violence prevention messages be relevant to these groups or their constituencies? If so, which ones?

Summary: Eleven out of 15 respondents who reported participation in coalitions said that violence prevention messages would be relevant to these groups or their constituencies. Two said they weren't certain.

WORKING GROUPS

Questions on working groups were asked in order to find out what other venues exist for the coordination of resources among HEALTH staff, i.e. what groups exist that may directly or indirectly have a stake in violence prevention and how can we coordinate resources.

Summary: Fourteen respondents reported participating in 18 working groups within the health department. Many of the activities of these groups revolved around communication issues and policy development.

19. Are you a part of any work groups within the health department? If so, which ones? / 20. How often do these groups meet?	**21. Please describe the activities or purpose of this (these) group(s).**
• Ad Hoc Communications Committee — Monthly	• To discuss communication issues
• Bill Waters Group	• To discuss HEALTH issues, e.g. staffing shortages
• Breast Feeding Task Force — Monthly	• To discuss breast feeding issues
• Communications Group (Family Health)- — Monthly	
• Data Subgroup (Family Health) — Monthly	
• Data Team — Monthly	
• Diabetes Public Education group — Monthly	• To discuss media efforts
• Executive Committee	• To discuss and approves policies, make decisions for the Department
• Health Care Quality — Monthly	
• Hospital Association	• To discuss hospital issues, e.g. Latex allergies
• Hunger Task Force — Monthly	• To discuss issues of hunger in RI
• Male Involvement Team — Monthly	
• Materials Review (Family Health)	• To make sure materials meet federal guidelines
• Obesity Task Force — Monthly	• To discuss obesity in RI
• Oral Health Steering Committee — Monthly	• To discuss oral health issues
• PR Team — Monthly	
• Safety and Health Committee — Monthly	
• Starting Right — As needed	
• Surveillance Group (communicable diseases) — Weekly	• To discuss surveillance issues
• Surveillance Team — Weekly	• To discuss and get feedback on surveillance and evaluation issues
• Worksite Health Committee — Monthly	• To develop internal policies for HEALTH • To plan fairs, presentations, e.g. related to employee health
• Worksite Wellness — Quarterly	• To discuss how HEALTH can become active in worksite wellness

INTERNET RESOURCES

22. Does your program have a web site? Internet resources are one means to widely distribute violence prevention messages. This question is intended to find how best to utilize internet technology to reach our focussed populations. Linking among web sites can help expand the range of audience receiving health messages, including violence prevention.

Summary: Respondents representing 6 programs stated that their program/office does have a web site on the Department of Health's home page. Several programs stated that their programs are in the currently developing web site.

• RI Cancer Control Program (Women's Cancer Screening program information found here)
• RI Tobacco Control Program
• Communicable Diseases in RI (HIV/AIDS information found here)
• Kids Hearing/RI (Early Intervention program information found here)
• Office of Minority Health
• Facilities Regulations

Note: Worksite Wellness Council of RI is listed on the HEALTH web site under Programs and Services/Other Coalitions.

a. If so, would you be willing to make a link from your site to the violence prevention program web site?

Summary: Six respondents representing 5 programs said that they'd be willing to make a link from their web sites to the Violence Prevention Program web site. The respondents who said their web sites are in development also stated a willingness to create a link after their sites are completed.

23. Do any of the organizations you work with have web sites that you know of?

Summary: Eight respondents said organizations they work with have web sites. Eight respondents said the organizations they work with either do not have web site or they weren't certain if they did.

a. Which ones?

• American Cancer Society	• Department of Education
• American Heart Association	• Department of Health and Human Services
• American Lung Association	• Department of Transportation
• Managed Care groups i.e.*United Health Care	• Department of Environmental Management
• American Lung Association (local)	• WELCOA
• RI Dental Association	• Local wellness council
• Kids Count	• Hasbro Children's Hospital
• Governor's Highway Safety Office	• City of Pawtucket
• Governor's Policy Office	• City of Providence

b. Do you think any of these groups would be interested in setting up links to the VPP?

Summary: This question was difficult for people to answer since they cannot speak for these agencies or organizations, but one respondent thought United Health Care may be interested in setting up a link to the Violence Prevention Program. One respondent said her groups would probably be interested in setting up a link to the Violence Prevention Program, however she was not certain which ones. Six respondents replied that they didn't know if this would be likely.

c. If so, which ones? (shown by the asterisk in Q23a)

Other Resources (DATA, STAFF, TECHNICAL ASSISTANCE , FUNDING)

This question is intended to find other resources that had not been uncovered to this point.

24. In what other ways do you interact or reach out to your constituencies?

Summary: In addition to the resources listed prior, respondents stated providing the following additional resources to their constituencies:

• Public education
• Health education materials
• Attendance at monthly (or every six weeks) meetings
• Training
• Technical assistance
• Host satellite broadcasts
• Facilities inspection, and investigation of complaints to improve quality of care
• Personal presence
• Capacity building
• Meeting with people (including site visits)
• Participation in seminars and trainings
• Analysis of death certificates, Hospital Discharge Data, and surveys
• Advocacy for legislation related to improving technologies that will help in forensic investigations

25. What (other) resources do you have that (could) directly or indirectly impact violence prevention or its associated risk factors?

Summary:
• Access to providers who work with uninsured populations
• Access to consultants
• Access to staff of funded agencies for discussions
• Media knowledge
• Access to expertise in writing press releases
• Access to gunshot wounds database
• Technical assistance developing graphics and communication materials
• Data reports of trauma and demographics

OTHER CONTACTS

Questions 26 and 27 were asked to help guide the assessment process and to find out who might be natural allies in violence prevention.

Summary: Thirty-one people within the Department of Health were recommended for interviews. Names in italics are those in which interviews were conducted. Each respondent was asked to provide additional names of people who could provide further input into this process. As many of the suggestions were followed through on, however, they were prioritized for their ability to add perspective.

26. Who else within HEALTH do you recommend I speak who may have other resources that could assist violence prevention in RI?	
• Amy Zimmerman	• *Jan Shedd*
• Ron Caldarone	• *Bob Marshall*
• Brenda DiPaolo	• *Edna Poulin*
• Maria Mattias	• Magaly Angeloni
• Rosemary Chammat-Reilly	• Ana Pittman
• Maureen Ross	• Jana Hesser
• Carol Hall-Walker	• Peter Leary
• *Becky Bessette*	• Ellen Amore
• Andrea Vastis	• Sam Viner-Brown
• Jorge Garcia	• Bob Vanderslice
• *Laurie Petrone*	• Cheryl LeClair
• Sandra Clark	• Mia Patriarca
• *Peter Simon*	• Helen Drew
	• Dave Hamel

Summary: Forty recommendations of people from outside of HEALTH were made. Many of these people are from other government agencies including Department of Corrections (DOC), Department of Human Services (DHS), Department of Children, Youth, and Families (DCYF), Department of Elder Affairs (DEA), and the department of Mental Health, Retardation, and Hospitals (MHRH). Other are from other health institutions, professional groups, businesses, and community organizations. Generic listings in italics.

27. Recommendations outside of HEALTH

Government Agencies
- DOC-Roberta Richman
- DOC-Dr. Ann Spalding
- DCYF-Mike Burke
- DEA-Cathy McKeon
- DEA-Tony Zompa
- DOC HIV Prevention-Terry Foley
- DHS-Sherry Campanelli
- MHRH-Katherine Power

Health Institutions
- College Health Services
- Rhode Island College-Tracy Carvela
- Native American Health Center-Dr. Kahn
- Rhode Island Hospital-Carole Jenny, MD
- *Health Centers*

Professional Groups
- Rhode Island Dental Association-Valerie Donnelly
- New England Drug Abuse centers- Francine Knowles
- Public Health Association- Francine Mantac
- Academy of Pediatrics-Rosalind Vaz, MD

Community-based Groups:
- Drug/Alcohol Task Forces
- Youth Pride-Michelle
- Youth in Action
- Sojourner House- Dee Dee
- MAP- John Regan

Schools
- *Dental Hygiene Schools in RI (2)*
- *Student Assistance Programs*
- *Physical Education teachers*
- *School-Based Health Centers*
- Training school

Other
- RI Parent Information Network-Elizabeth Priestly
- David Finklehor
- Toby Simon
- Women's Commission-Toby Ayers
- Hasbro/EMSC/Safe Kids/Safe Comm.-Tom Lawrence
- Linda Katz- RI Health Center Association
- REACH-Don Mays
- Governor's Justice Commission-Joseph Smith
- United Way-Allan Stein
- *Religious Groups*
- *Business Groups*
- *Insurers*

Part Two: Department of Education Responses

As mentioned earlier, HEALTH works in collaboration with *Healthy Schools! Healthy Kids!* HSHK!, Rhode Island's initiative to support comprehensive school health programs. It is funded by the Centers for Disease Control and Prevention to prevent health problems and to improve educational outcomes of students. Comprehensive school health addresses eight key components several of which address improved school safety and violence prevention.

HSHK! provides several valuable resources to HEALTH that can impact future violence prevention efforts. The first of these resources is Information Works!, a statistical profile of each school within each school district in the state. Included in this data are the number of school suspensions. While this data alone may not indicate problems of school violence, it may be combined with other data sources to help guide school violence prevention efforts. See http://www.infoworks.ride.uri.edu for more on Information Works! Other sources of data include SALT survey data, which includes data about perceived school safety and actual violent incidents in particular schools and school districts throughout Rhode Island (For more information on SALT go to http://www.infoworks.ride.uri.edu/2000/salt.htm).

In addition to these data sources, HSHK! has a resource center housed at the Department of Education. This center includes books, articles, and videos on health topics, including violence prevention as well a computer with internet access. Health education curricula for each school district are also located here. These curricula may serve as a resource for the VPP, however, many of them are not currently up to date. All schools will be asked to submit updated versions of their own health education curricula by the end of 2000 (The HSHK resource center can be accessed at: http://www.ri.net/RIDE/health/Bibliography/toc.html).

Finally, the Department of Education administers the federal Safe and Drug Free Schools, a program to reduce tobacco, alcohol, and other drug use and violence, through education and prevention activities in schools. Part of the program includes providing money to states to establish, operate and improve local programs of school drug and violence prevention, early intervention, rehabilitation referral, and education in elementary and secondary schools (For more information about this national program go to: http://www.ed.gov/offices/OESE/SDFS/index.html).

The Department of Education also operates the Student Discipline Record System, a system of tracking disciplinary actions in RI public schools that result in expulsion, in-school or out-of-school suspensions, or placement into alternative programs. All school violence incidents are expected to be recorded in this database. Each school is required to submit this information to the Department of Education once a year. For more information about this resource **see page 72**.

These combined data sources can help prevent youth violence in Rhode Island.

For other interview information with HSHK! respondents **see Appendix E.**

Part Three: Final Conclusion/Next Steps

The internal assessment survey reported on here provided a wealth of information to the Violence Prevention Program. The participation of all respondents was greatly appreciated. It contributed significantly to the program's goals and objectives and has spurred many ideas to guide future violence prevention initiatives. It is the hope that the VPP will forge lasting partnerships and collaborations with these respondents and their respective offices/programs within HEALTH.

This assessment, however, is just one piece of a larger strategic planning effort. Next steps in the Violence Prevention Program's strategic planning process include **(See Flowchart on page 31):**

EXTERNAL ASSESSMENT:
Many individuals, groups, and agencies are already invested in violence prevention in Rhode Island. Others may be interested, as determined in this assessment. The VPP will talk to representatives from these various groups with the goal of determining how HEALTH can best collaborate and contribute to future violence prevention initiatives. The external assessment process will include the following steps (order to be determined):

- **Assess external (to HEALTH) violence prevention resources**

Individuals, groups, and organizations/agencies contribute very valuable resources to violence prevention in Rhode Island as determined in part by the Directory of Violence Prevention Interventions developed by the Rhode Island Anti-Violence Coalition. By cataloging these resources the VPP can better determine how it can efficiently use its resources to add to the pool of violence prevention initiatives.

- **Discuss what resources HEALTH has to contribute**

The VPP also hopes to show our potential partners at this time, what resources (based on this internal assessment) HEALTH and HSHK have to contribute to violence prevention in Rhode Island. These resources include those listed on page 1 and have been enhanced with those gathered in the internal assessment process.

- **Assess external needs**

The VPP will begin to assess the needs of community groups working in violence prevention in order to best plan how it can contribute to, and advocate for, the advancement of these needs.

- **Compile the internal and external assessment results into a report**

A final report will be written that compiles results from both the internal and external assessments. This report will highlight: available resources within HEALTH that either directly or indirectly impact violence or its related risk factors, similar resources within the community and other government agencies, needs of other agencies and groups working in violence prevention, and a set of preliminary "next steps" for the VPP.

DEVELOPMENT OF STATEWIDE GOALS FOR VIOLENCE PREVENTION:

Based on the internal and external assessment findings, the VPP, along with any and all interested groups within the community working to reduce violence or its risk factors, will work together to develop goals for statewide violence prevention. The steps in this process are envisioned as follows:

- **Convene a group of people to develop shared statewide violence prevention goals.**

After a report and preliminary recommended actions for HEALTH have been created, the VPP will convene a meeting of individuals from HEALTH, other government agencies, and from groups in the community working in violence prevention, to develop shared statewide violence prevention goals.

The purpose of these statewide goals is twofold: to guide violence prevention activities among all interested groups working on this issue in Rhode Island and to allow each group/agency to form (revise or continue) their own action steps based on these goals and their own agency missions and capacity.

The desire for subsequent follow-up meetings to discuss progress toward these stated goals will be discussed at this meeting.

- **Developing HEALTH activities based on statewide goals**

Once broad statewide violence prevention goals have been made, HEALTH, as stated above, will work within its public health framework and its mission to determine activities commensurate with these goals.

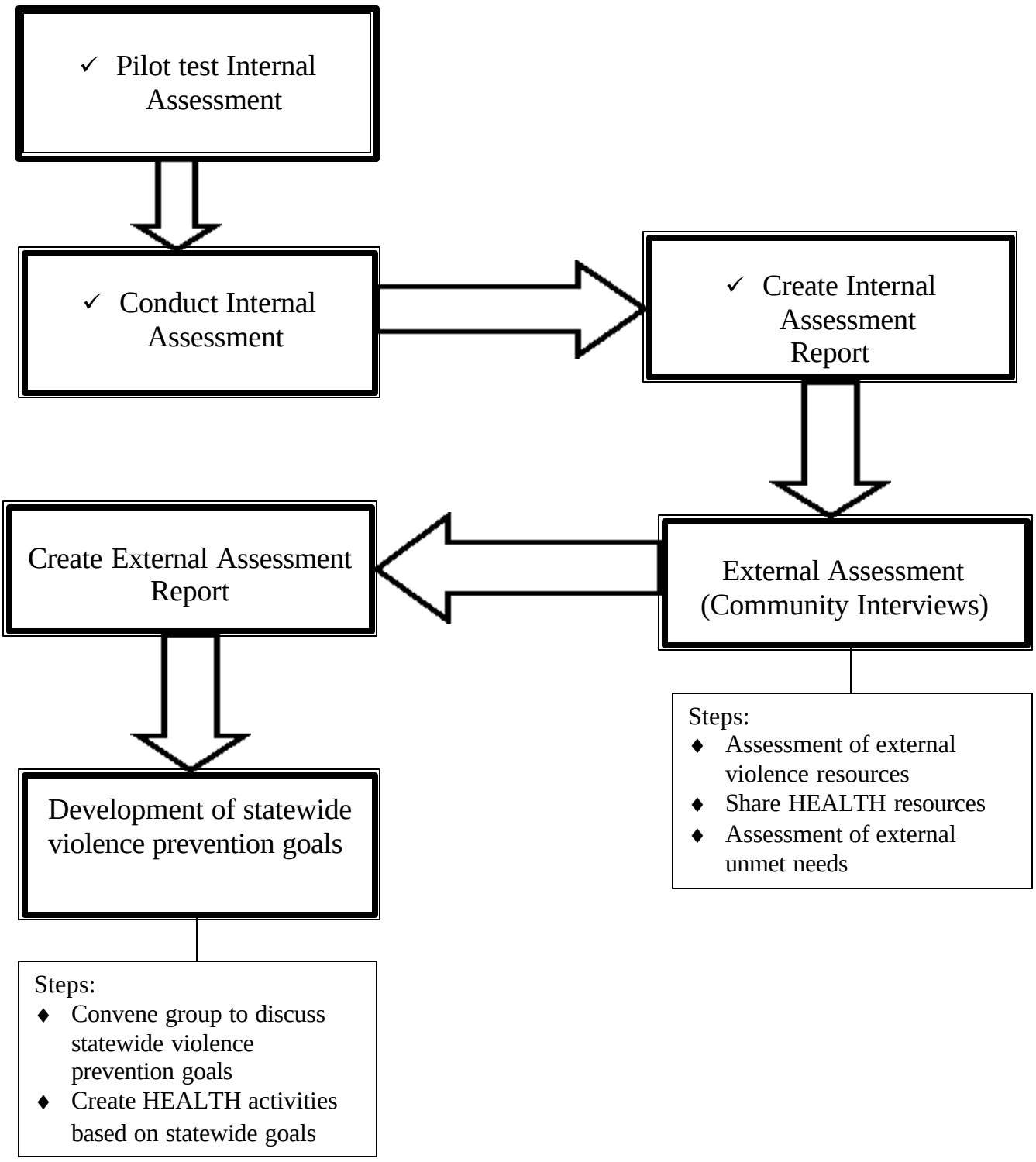
Example: A possible statewide goal may be "To secure funding for violence prevention programming in Rhode Island." HEALTH may respond by creating the following activity: "To disseminate information on opportunities for funding of violence prevention programs to community agencies working to reduce violence in Rhode Island."

Other agencies may choose to focus their activities on other of the statewide goals that more closely address or fit their agency mission and capacity. Ultimately, we may be able to impact violence in Rhode Island in the a coordinated, efficient, and effective manner.

For other possible HEALTH action steps based on the internal assessment, see recommendations on pages 5-7.

For more information about next steps in the strategic planning process or to participate in the external assessment, please call Deb Stone at 222-1394, ext. 134 or email DebS@doh.state.ri.us.

Strategic Planning Process Flowchart



APPENDICES

Appendix A
Background Material

PURPOSE OF THE SURVEY

The first step in the strategic planning process is to conduct an internal assessment survey within the health department. Survey questions ask about resources that exist within the health department that either directly or indirectly impact on violence or its risk factors, among Rhode Islanders of all ages. The results of this internal assessment will be used to show our partners in the community and in other state agencies the resources that the Department of Health has to offer which may assist in their violence prevention efforts. We will then ask these partners what other services or resources they need in order to function more efficiently/effectively. Our ultimate goal, with input from our partners, is to use our resources to fill a defined niche and a unique role within the violence prevention community. This process will ultimately make the health department more visible, more accessible, and clearer in its role to help prevent violence in Rhode Island and will thereby improve the health of the community.

DEFINITIONS

Violence:
The CDC defines violence as, "The threatened or actual use of physical force or power against another person, against oneself, or against a group or community which results in or has a high likelihood of resulting in injury, death, or deprivation.

The Violence Prevention Program focuses specifically on injurious assaults, homicides, suicide, and suicide attempts. Keep in mind that violence occurs at work, at home, in schools, in families, and in the community among and toward people of all ages, races, religions, and sexual orientations.

Resources:
Resources are broadly defined as: funding, staff, data (violence specific surveillance data, hospital data, death certificate data, other injury or surveillance data, etc) direct services, publications, public education, technical assistance, or other services provided to the public not otherwise specified.

RISK FACTORS

Some risk factors for suicide:
Previous suicide attempt
Mental disorders e.g. depression or bipolar disorder
Co-occurring mental and alcohol and substance abuse disorders
Family history of suicide
Hopelessness
Relational, social, work, or financial loss
Physical illness
Easy Access to lethal methods

Some risk factors for other violence:

Community factors
Availability of firearms
Community laws/norms that favor drug use, firearms, and crime
Violence in the media
Low attachment to neighborhood
Extreme economic deprivation

Individual/Peer factors
Childhood victimization
Friends engage in violence
Early initiation of violence
Constitutional factors
Unemployment/economic instability
Lack of recognition/stake in the community
Disconnection from support systems

School factors
Early academic failure
Lack of commitment to school
Early/persistent antisocial behavior

Family factors
History of violence
Conflict
Management problems
Parents' attitudes about violence

Appendix B.
Internal Assessment

Name_____ Division/Program_____

Date _____ Job Title _____

Introduction

As you may recall from the email that was sent to you, the Violence Prevention Program is in the process of doing strategic planning around ways to expand its focus from the prevention of violence against women to other kinds of violence. The first step in this process and the purpose of this interview is to assess the types of resources that the health department currently has that may impact on violence or its associated risk factors. Violence is defined as:

"The threatened or actual use of physical force or power against another person, against oneself, or against a group or community which results in or has a high likelihood of resulting in injury, death, or deprivation."

Keep in mind that violence, including suicide occurs in all settings and among all populations. Some of the risk factors for violence are shown here (see attachment).

The following questions ask you about the work that you do, the populations your work impacts, the groups you partner with to reach these populations, and the resources you provide to your partners and/or constituencies.

[If you choose to complete any part of this survey prior to our scheduled interview time, please email me your responses or drop them off in Room 409. Thank you.]

Section 1: Mission and Responsibilities- The purpose of this first section is to learn more about what your responsibilities and range of activities within your division are.

1. What program(s) within your division do you oversee or do you work for?

2. What is the mission of your program (or division, if interviewee is responsible for more than one program)?

Section 2: Constituencies- The purpose of section two is to understand the range of populations that the majority of your work focuses on and in what settings you reach these groups. Later questions will ask if you think violence prevention messages are relevant to these populations or the groups working with them.

3. What population(s) does your work most directly impact and in what settings do you work with these populations? (Place a check mark in all of the appropriate boxes)

Setting/ popula-tion	General RI population	People with special health needs	Men	Women	Adults (Men and women)	Children/ teens	Elderly	Specific ethnic groups	Un(der)in-sured	Other*
schools										
Prisons/ Jail										
Hospitals Health Care										
Work-place										
CBO's										
Com-munity										
Other*										

- Please describe:

Section 3: Written Materials and Publications- The purpose of section three is to learn about the types of publications you distribute and whether or not you think violence prevention messages may be appropriate to include in any of these publications.

4. Does your program develop publications to be distributed to these constituencies?
Γ Y Γ N (Go to Q5)

   a. What type of publication is distributed? To whom? How often?

   b. Would violence prevention messages be appropriate material to include in these publications? Γ Y Γ N or Γ DK (Go to Q4d)

c. If yes, in which publications? Circle in 4a above.

d. Who is responsible for determining the content of these publications?

Section 4: Partners - The next set of questions ask about groups that you work with in various kinds of ways: as funding sources for, as collaborators with, and/or as part of a coalition. The purpose is to get an understanding of the range of your partnerships, the types of activities you work on together, and the kinds of resources you provide to these groups.

5. What agencies, community organizations, or other groups do you **fund**? (If none, go to Q9)

a.
b.
c.
d.
e.
f.

6. Please briefly describe what this (these) group(s) are funded to do?

a.

b.

c.

d.

e.

f.

7. What resources other than funding do you provide to this (these) group(s)? (i.e. publications, training, technical assistance, training, data analysis, etc.)

8. Would violence prevention messages be relevant to these groups or their constituencies? If so, which ones? (Place a check next to each one in #5 above)

9. What agencies or organizations do you **collaborate** with?

a.
b.
c.
d.
e.
f.

10. How often do you interact with these groups? (Record response next to each in Q9)

11. Please briefly describe the nature of this collaboration including any events or policy issues you plan or work on together?

a.

b.

c.

d.

e.

f.

12. What resources other than your participation do you provide to this (these) group(s)? (i.e. publications, training, technical assistance, training, data analysis, etc.)

13. Would violence prevention messages be relevant to these groups or their constituencies? If so, which ones? (Place a check next to each one in Q9 above)

14. What **coalitions** are you a part of? (If none, go to Q19)

a.

b.

c.

d.

15. How often do you interact with these groups? (Record response next to each in Q14)

16. Please describe the nature of your involvement in these groups, including any events or policy issues you work on together?

a.

b.

c.

d.

17. What resources other than participation do you provide to this (these) group(s)? (i.e. publications, training, technical assistance, training, data analysis, etc.)

18. Would violence prevention messages be relevant to these groups or their constituencies? If so, which ones? (Place a check next to each one in Q14 above)

Section 5: Working Groups- Section 5 asks about the kinds of working groups that exist within the health department and their respective purposes with the idea that these groups may offer other expertise for violence prevention planning.

19. Are you a part of any work groups within the health department? If so, which ones?(If none, go to Q22)

a.

b.

c.

20. How often does this group(s) meet? (Record response next to each in Q19 above)

21. Please describe the activities or purpose of this (these) group(s).

    a.

    b.

    c.

Section 6: Internet Resources- The purpose of this section is to learn about the internet as another possible means of conveying information.

22. Does your program have a web site? Γ Y Γ N or Γ DK (Go to Q26)

    a. If so, would you be willing to make a link from your site to the violence prevention program web site? Γ Y Γ N

23. Do any of the organizations you work with have web sites that you know of? Γ Y Γ N or Γ DK (Go to Q24)

    c. Which ones?

    b. Do you think any of these groups would be interested in setting up links to the VPP? Γ Y Γ N or Γ DK (Go to Q24)

    c. If so, which ones? (Circle above)

Section 7: Other Resources (data, staff, technical assistance, funding)- The purpose of this section is to find out about other ways in which you reach your constituencies that have not been mentioned so far.

24. In what other ways do you interact or reach out to your constituencies?

25. What (other) resources do you have that (could) **directly or indirectly** impact violence prevention or its associated risk factors?

Section 8: Other Contacts

26. Who else within the health department do you recommend I speak who may have other resources that could assist violence prevention in RI?

Appendix C
Department of Health Individual Responses

RESPONDENTS

1. Sharon Marable	Assistant Medical Director/Division of Disease Prevention and Control
2. Mary Anne Miller	Chief/Office of Primary Care/Division of Disease Prevention and Control
3. Betty Harvey	Project Manager/Tobacco Control/Division of Disease Prevention and Control
4. Carol Hall-Walker	Field Director/Tobacco Control/ Division of Disease Prevention and Control
5. Frank Donahue	Development Officer/Management Services/Office of the Director
6. Lucille Minuto	Assistant Administrator/Office of HIV&AIDS/Division of Disease Prevention and Control
7. Maureen Ross	Sr Public Health Promotion Specialist/Office of Primary Care/Division of Disease Prevention and Control
8. Bill Hollinshead	Director/Division of Family Health
9. Jan Shedd	Chief/Adolescent and Young Adult Health Unit/Division of Family Health
10. Madeline Vincent	Chief/Facilities Regulations/Division of Health Services Regulation
11. Helen Drew	Legislative Liaison/Office of the Director
12. Marcia Campbell	See Part Two
13. Marie Stoeckel	Chief/Occupational and Radiological Health/Division of Environmental Health
14. Jay Buechner	Chief/Health Policy and Planning/Office of Health Statistics/Office of the Director
15. Elizabeth Laposata	Medical Examiner/Office of the State Medical Examiner
16. Dave Uliss	Chief/Health Laboratory/Forensic Science/Division of Environmental Health
17. Office of Minority Health web site	/Office of the Director
18. Ron Caldarone	Chief/Office for Children with Special Health Care Needs/Division of Family Health
19. Bob Marshall	Assistant Director of Health/Office of the Director
20. Jackie Harrington	See Part Two
21. Laurie Petrone	Chief/ Family Health/ Office of Policy and Information
22. Peter Simon	Asst Medical Director/Division of Family Health
23. George McDonough	See Part Two
24. Edna Poulin	Chief Program Health Evaluator/Office of the Director
25. Peter Leary	Chief/Emergency Medical Services/Division of Health Services Regulation
26. Becky Bessette	Chief/Women, Infants, and Children Program, Division of Family Health

MISSION AND RESPONSIBILITIES
1. What program(s) within your division do you oversee or do you work for?
1. Oversees medical policy and planning for the Office of Primary Care and the Office of Health Promotion and Chronic Disease Prevention
2. Oversees Office of Primary Care (OPC) programs (Diabetes, Women's Cancer Screening, Oral Health, Osteoporosis).
3. RI Tobacco Control Program; Betty is the liaison to the Native American group, creates materials for campaigns, oversees public education, and does other administrative tasks.
4. Tobacco control and prevention
5. Management Services as a development officer and part-time legislative liaison
6. HIV/AIDS prevention
7. *Healthy Schools! Healthy Kids!* Oral Health Initiative for School-aged Children; Primary Care Cooperative Agreement; National Health Service Corps (NHSC) Student Experiences And Rotations in Community Health (SEARCH) Program; NHSC State Loan Repayment Program (SLRP – RI Health Professional Loan Repayment Program); Rural Health.
8. Oversees WIC, Reproductive Health, Women's Health Screening, Family Planning, Lead, Injury
9. Adolescent and Young Adult Health Unit; Oversees Family Planning, After school program, middle school health education mini grants, Men 2B, School-based health centers
10. The Division oversees the regulation of over 20 types of facilities
11. Legislative affairs; Serves as liaison to community agencies and municipalities (recruitment for different boards and committees from minority communities; participation in community activities)
12. See Part Two
13. Oversees the OSHA consultation, asbestos control, environmental lead, radiation control, and radon control programs
14. Oversees Office of Health Statistics
15. Oversees investigation of cause of death, autopsies
16. Drug testing for illegal substances; analysis of medical examiner samples to help determine cause of death; analysis of evidence from violent crime scenes to help identify the perpetrator, i.e. DNA and CODIS; analysis of blood in drunk driving cases; certification of police to perform breath analysis.
17. Oversees minority health work and staffs the Minority Health Advisory Committee
18. Early Intervention, perinatal screening for developmental disabilities, genetics.
19. Supports the work of the Director; spokesman for the Dept, oversees web development, provides press releases on behalf of the Director.
20. See Part Two
21. Health Communications Unit and in charge of policy (Bill Hollinshead's Assistant); Oversees family health information line, distribution center, strategic planning, and interagency projects.
22. Oversees all programs in Family Health as Assistant Medical Director
23. See Part Two
24. Worksite Wellness Committee (Department) and Liaison to the Worksite Wellness Council; in charge of health risk appraisal for employers and schools (liaison to these groups)
25. Responsible for the planning, development, and administration of a comprehensive statewide

plan for emergency medical services. Licenses ambulance services, vehicles, and emergency personnel. Coordinates training program for Emergency Medical Technicians. Establishes treatment protocols for pre-hospital care providers.
26. Oversees WIC contracts, quality of WIC services, and reporting information to the Federal Government.

.

2. What is the mission of your program (or division, if interviewee is responsible for more than one program)?
1. The Division's mission is generally to improve access to primary care and to implement health promotion programs.
2. To increase access to comprehensive, culturally competent primary care for all RI with a focus on underinsured and vulnerable populations. OPC works with and through a cooperative agreement with the states' largest safety net provider, which is the Rhode Island Health Center Association. This cooperative agreement is supported by the federal Bureau of Primary Health Care, (BPHC) and includes other BPHC programs such as the Travelers Aid, the states' largest homeless program. In addition, other special populations that have been designated through our efforts and the evaluation of the federal Division of Shortage Designation as Health Professional Shortage Areas (HPSAs). We work with the primary care provider community to enhance access through health professional loan repayment programs.
3. To reduce prevalence of smoking in Rhode Island. Also, to create policy change via media advocacy, etc.
4. To address tobacco control through legislation, education, media advocacy, surveillance, and evaluation
5. Mission of the Health Dept (To prevent disease and to protect and promote the health and safety of the people of Rhode Island)
6. To prevent the spread of HIV/AIDS
7. Mission of the Division of Disease Prevention and Control (To increase the span of healthy life for all Rhode Islanders by developing and advocating for prevention, by promoting healthy lifestyles, and by improving access to effective primary care.) and the Office of Primary Care (See #2 above).
8. Preserve, promote, protect health and development of children and their families. (Title 5 mandate)
9. Develops, leads and manages programs that address the health and development needs of school age youth and young adults. (See attachment)
10. To license and to certify.
11. Same as Health Dept
12. NR
13. To reduce exposure to chemical agents and ionizing radiation for the general population.
14. To collect, maintain, and analyze health statistics for the public.
15. The investigation of unexpected deaths, injury deaths, some hospital deaths, and deaths of children under 18 (my words)
16. To provide expert scientific opinion, based on examination of criminal evidence, to law enforcement agencies and the courts, in an effort to aid investigations and help determine guilt or innocence of the accused.
17. The mission of the Office is to facilitate access for racial and ethnic minority communities to

health information, education and risk reduction activities; and to develop policies, plans and tracking systems for ensuring that the needs of these communities are integrated and addressed within all Department programs.
18. EI- to assure every family that has a special needs child receives support, technical assistance, and services needed to keep these families in the community functioning at the highest quality of life possible.
19. To support the work of the Director in the development of public health policy and to get information out to constituencies (see Q3)
20. NR
21. To create population based strategies to change behavior using communications and health education strategies.
22. See #8
23. NR
24. Works from the health dept's mission and from the mission of the worksite wellness council, "to promote and support worksite health promotion initiatives which meet or exceed national standards."
25. To license emergency medical services and to develop standards of care.
26. The mission of WIC is to provide nutritious supplemental foods, nutrition education, and linkages to other health care and social services to participants during critical times of growth and development.

CONSTITUENCIES

3.What population(s) does your work most directly impact and in what settings do you work with these populations? (Place a check mark in all of the appropriate boxes)

Setting/ popula-tion	General RI population	People with special health needs	Men	Women	Adults (Men and women)	Children/ teens	Elderly	Specific ethnic groups	Un(der)in -sured	Other
schools	4			21	4,22	3,4 6, 7, 8,9,13, 22		4	7	
Prisons/ Jail			9	6	6, 7, 22	22				
Hospitals Health Care	3, 4, 7, 10, 25	10, 21 25	4,10, 21	4,9,10, 21, 26	4,10,21 22, 25	7,8,9, 10, 18, 22, 25, 26	10	10,17	3,7,10, 21	10
Work-place	3,4		4,9,21	4,21	4,13,21 , 22,24	4,22	4	4		
CBO's	3, 4,7	21	4, 21	4, 21	6, 21, 22	6, 3, 8, 22		4,6, 17,21	6, 7	6
Com-munity	4,5, 6, 13,14 21		4	4	4,22	4,8, 22	4	4,17		
Other	3	21	21	21	13	8, 18		17		7, 11,19

Comments/Other Settings and Constituencies

1. General RI population, elderly, specific ethnic/racial groups, underinsured, homeless in schools and corrections (question for this respondent was from an earlier version of the survey and didn't separate out which population is reached in which setting.).

2. Constituency is the entire state population with a special emphasis on the uninsured and populations that are socio-economically challenged. We work with the primary care provider community, academia and other special populations such as the homeless and the ACI. The process of evaluating unmet professional provider needs enables us to interface with a wide variety of constituents. Settings: CBO's and Primary Care Providers and Organizations. (Constituency and Setting population question asked separately in this interview)

3. Media

6. At risk populations/Five Priority Groups:
(Each targeted in different setting but mainly in Providence, Pawtucket, Central Falls, Woonsocket)

- Injecting drug users, High risk women (IDU/sex workers/minority), Men who have sex with men, High risk youth (teens with STDs, pregnancy, victims of abuse, Prison population (m/f)

7. Professional organizations/societies; health professions training programs

8. Child Opportunity Zones (COZs), parent networks

10. Works with populations that reside (permanently or temporarily), or in any way receive services, in health care facilities. Also, regulates tattoo parlors.

11. Policy makers (particularly those from the General Assembly) and other policy makers from other government agencies. Ultimately the general RI population is the constituency.

13. Homes

14. The RI Population, PH researchers, schools, worksite wellness, employer based health insurance companies, Hospitals, United Way and other voluntary organizations, CBO's, DOT, DHS, DOE, and legislators

15. Law enforcement, physicians, hospitals.

16. Law enforcement, criminal justice

17. Churches, housing authority, senior centers

18. Children and teens (and their families) in their homes

19. Policy makers, business people, the public, the media

21. Providers; other settings to reach people include: libraries, fast food restaurants, child care providers, laundry mats

24. Employers; The ultimate constituency is the workforce.

25. The focus is on pre-hospital care with a special emphasis on the children's care.

WRITTEN MATERIALS AND PUBLICATIONS

4. Does your program develop publications to be distributed to these constituencies?

Yes (17 out of 22 replies)	No (5 out of 22)
1, 2, 3, 4, 5,6,7,8,9, 14,18,19,21, 22,24, 25, 26	10, 11 (not independent of community affairs) 13 (mostly adapt EPA publications), 15, 16

a. What type of publication is developed? To whom is it distributed and how often?

Newsletter	Other	To Whom	How Often
5&19 Director's Newsletter		Policy Makers	Quarterly
	2. Health Information • Women's Cancer Screening Program • Program information about State Loan Repayment Program • SEARCH Program information	• Providers • CBOs • Colleges and Universities that educate primary and dental health care provider students	
3. Newsletter	3. Brochure on diabetes and smoking • Manual on tobacco control	• People with special health needs • Funded groups • General RI population, legislators, and providers	Monthly
4. Tobacco Control		General RI Pop	Monthly
6. Morbidity-Mortality Report		HIV Prevention Professionals and providers	Seasonally
	7. Program brochures • Pamphlets • Flyers • Provider Surveys	Program Applicants, participants Primary Care Providers	
	8. Public education material	Public	On-going
	9. Ten Tips • Policy Briefings	Families Schools	After 3/15
	14. Journals • Policy briefings • Data requests	Legislators, public	Ongoing
	17. Fact Sheets, • Health of minorities in RI • Healthy RI 2000 • Minority health data symposium report		

	21. Public education materials via order forms, bulk mailing to CBO's etc, or at health fairs, etc.	Public, CBOs, Legislators	Depends on what issues is being highlighted at any given time
	24. Adult wellness checklist • Brochure *literature from Worksite Wellness Council of America	Employers	On-going
	25 State regulations • Protocols • Comfort One manual	• EMS providers • EMS providers/Hospitals • Hospitals/ Hospices, physicians, nursing homes, extended care facilities, elderly residential facilities, hospital discharge planners, Visiting Nurses Association	
	26. General Program information	Hospitals, doctors, agencies, businesses	

Other Comments

1. B&C program has brochures and pamphlets. Injury has lots of materials. Diabetes has multimedia materials including TV spots. Osteoporosis uses the internet to disseminate information, and Tobacco Control funds other groups who develop materials. Each program has its particular focus including individuals, agencies, community groups, providers, etc.

7. *In the future, looking to provide continuing education for dentists which will include some literature.

21. Posters, brochures, radio, TV spots; People either order materials, or bulk mailings are sent out, and some information provided at health fairs. The frequency of distribution depends on what month it is and what health area is being highlighted, e.g. April is immunization month, September is Adolescent Health month, and May is lead month.

22. See #8,9,18,21

b. Would violence prevention messages be appropriate material to include in these publications?

Yes (13 out of 17)	No (3 out of 17)
1,2, 5, 6, 7,8, 9, 13 14, 19, 21, 24, 26	3, 4 , 25

c. If yes, in which publications? / Other comments

1. Yes, but, it depends on how you phrase the messages. Single over-riding health communication objectives (SOHCOs) would be appropriate, and also based on the target audience these messages would need to be tailored.

2. Particularly women's cancer screening program materials, diabetes, and oral health (if resources were provided to do so)

3. Don't know

4. No, unless there is a conference coming up and an insert can easily be included.

8. Those having to do with lead, early intervention, women's health screening

13. Maybe related to OSHA

21. Related to adolescent health and home visiting program

24. Welcoa information, but this is up to Welcoa

26. In referral information

d. Who is responsible for determining the content of these publications?

4. Carol and staff of tobacco control; media committee

5. Director's office and Jay Buechner

6. HIV Staff

7. OPC staff

8. Communications staff/Laurie Petrone (meetings on Thursdays)

9. Staff of communications committee

19. Bob

21. Communications and program staff

24. Welcoa

26. Local agencies

PARTNERS

5. What agencies, community organizations, or other groups do you fund?

2a. Loan repayment program to primary and dental care providers in underserved areas
b. National Health Service Corps SEARCH program
c. CBO's via Diabetes and Women's Cancer Screening programs

3a. 35 Task Forces
b. Miriam Hospital
c. Rhode Island Indian Council
d. Urban League
e. Socio-Economic Development Center
f. American Lung Association of RI
g. Youth in Action
h. Initiatives for Human DevelopmentDuncan Avenue Arts
i. Pawtucket Family YMCA
j. Institute for International Sport
k. Media Consultants
l. Progresso Latino
m.City of Providence
n. YWCA of Greater RI
o. RI Indian Council
p. 3 school departments

4a. American Lung Association
b. Dept of Ed. (3 regional offices)
c. *Substance Abuse Prevention Task Force (All 35)
d. *SEDC; Urban League, Progresso Latino, RI Indian Council
e. *13 youth advocacy groups
f. Miriam Hospital Center for Behavioral Medicine; Pharmacy Ed.

6a. 11 Community-based Organizations (AIDS Care Ocean State, AIDS Project RI, Caritas/Corkery House, Jammart, John Hope Settlement House, MAP, New Visions of Newport County, Progresso Latino, Providence Center, Urban League, IHD
6b. DOC

8. Community Health Centers
b. Public Health Nursing
c. Hasbro Children's Hospital
d. Women and Infants
e. Memorial Hospital
f. Schools

9a. 11 family planning clinics
b. School based health centers

c. Men 2 B in 4 agencies
d. 4 CBOs for health education (New Visions, Dawn for Children, Project Hope, Urban League)

14a. Contractors for BRFSS
b. Contractors for Health Interview Survey
17a. 16 agencies
b. 12 mini grants provided as well

18a. 5 EI sites
b. Rhodes Center at RI Hospital
c. RI School for the Deaf
d. Hearing assessment program
e. Traumatic Brain Association
f. Family Voices

22. (see 8, 9, 18, 21)

26. 22 Health Centers

6. Please briefly describe what this (these) group(s) are funded to do?
1. see #4

3. See #4

4. a. Tobacco Control and Prevention
b. Advocacy to promote item a
c. Needs Assessment
d. Community Education/Events

6a. Outreach, HIV education and prevention
6b. HIV Prevention Case Management, community planning, capacity building, HIV prevention in underserved and minority communities

8. Family Planning, WIC, Immunization
b. Home visits
c. Children's immunization
d. Family Planning/WIC
e. Community partnerships/ Family Medicine community oriented
f. School based health centers funded in 30 Cozs and 6/7 school-based health centers

9. Family planning, clinical work (pregnancy testing, STD counseling and testing, treatment health screening)

14. a. BRFSS collects health data and asks some questions about IPV but this module is not permanent.

b. This survey asks about emergency department visits and the interviewee is a proxy for the entire household so it's not a very good sample for asking about violence necessarily.

17a. Funds awarded to not-for-profit community-based organizations that develop and implement comprehensive minority health promotion centers that address the preventable health conditions which lead to premature death for minority populations. Minority health promotion centers are responsible for conducting individual and community health risk assessments; conducting community outreach, providing health education, providing consumer empowerment activities regarding the health system, developing health information centers, and working with health care providers to provide health screening and referrals for health care.

18. Provide health services to kids with special needs

26. Administer the WIC program including providing breastfeeding advice and support for pregnant women and new moms, providing nutrition advice, providing referrals to doctors and social services. Checks given to women to buy healthy foods at local stores

7. What resources other than funding do you provide to this (these) group(s)? (i.e. publications, training, technical assistance, training, data analysis, etc.)

3. Training in media advocacy, community organizing

4. Training and technical assistance, sometimes data analysis, satellite broadcasts, Emergency Room training, Hairdresser training

6. Training via REACH (a group organized to help build capacity of CBOs serving populations at high-risk for HIV)
Technical Assistance-
Networking opportunities

8. Trainings-nutrition, intakes, training for family resource counselors
Materials- setting up distribution center
Consultation/expertise- help set standards, quality improvement, increase capacity
Day long talks/ statewide training

9. Adult learning, reproductive health, clinical training, asset development, conference organizing

17. Technical Assistance, data evaluation

18. Technical Assistance, training

26. Educational materials, training (e.g. prevent child abuse), statewide summary of WIC data once a year, reference materials, support to go to national conferences

8. Would violence prevention messages be relevant to these groups or their constituencies? If so, which ones?

Yes	No
1, 2, 3 (yes, maybe to the people these groups work with but not to the agencies themselves); 4, 6 (all), 8 (more resources and time needed for this) 9, 18 (except that they are too busy), 26	

9. What agencies or organizations do you collaborate with?

1. CBOs

2. CBOs
b. Providers
c. Academia

4a. American Heart Association
b. American Cancer Society
c. RI Parks and Recreation
d. RI Cancer Coalition
e. Media Outlets (also funded)

5a. HHS
b. DCYF
c. MHRH
d. Education
e. RI Foundation
f. Hospital Association
g. Governor's Office
h. Brown University Medical School
I. DEA
J. Children's Cabinet
*used to work with juvenile task force

6a. HHS interact less regularly
b. DCYF, interact regularly
c. DOE, interact regularly
d. DOC, interact regularly
e. Substance abuse division- regularly
f. Training School- regularly

7a. Safety net Providers (the state's largest program for the homeless, operates a dental clinic; several school-based health centers – SBHCs offer dental services)

b. RI Department of Human Services
c. RI Department of Education
d. Professional Oral Health Associations (RI Dental Association, RI Dental Hygiene Association, RI Dental Assistants Association)
e. School Nurse Teachers, School Oral Health Professionals
f. Department of Family Medicine, Memorial Hospital of RI, NHSC SEARCH Program

g. Health Centers (6 of 13 CHC's offer dental services)
h.Community-based hospitals (2 have dental programs)

8a. Adolescent Medicine/ Hasbro
b. Kids Count
c. *Schools/Dept of Ed. HSHK- all the time
d. Women and Infants
e. Memorial Hospital
f. Public Health Foundation
g. *DCYF (could do more with them)
h. *DHS
e. *MHRH- little contact
f. Dept of Transportation
g. Children's Cabinet

9a. HHS
b. DCYF
c. Dept of Labor
d. Education
e. RIC
f. United Way
g. *Youth Success Cluster
h. CBOs
i. Children's Cabinet
j. MHRH
k. *Family and Father Network

10a. DEA
b. DOH (prof reg, emergency med, disease control, managed care, etc)
c. DHS
d. DCYF
e. RI Health Association & RI Association of Facilities for the aged
f. Hospital Association and other Provider Groups

11a. *City of Pawtucket
b. *City of Providence
c. *Cancer Society
d. DEM
e. *RI Medical Society
f. *Dept of Ed.
g. *Governor's Policy Office
h. *Governor's Highway Safety Office
I. Dept of Transportation

13a. Federal Agencies (EPA)-ongoing
b. Childhood Lead Action Prevention Program- Monthly
c. Greater Elmwood Housing Association
d. Trade Groups
e. RI Safety Association

14a. DOT – once per month* (would be relevant to VP as it relates to motor vehicles as means of suicide attempts but there aren't many of these)
b.Dept of Education – as needed*
c. DHS – fairly regularly as there is a contract with them to share data*

d. Community Based Organizations – on-going as needed
e. Hospitals – regularly (includes psychiatric hospitals)

15. *AG's Office- as needed
b. *DOT- as needed
c. DOH- as needed
d. *Hasbro- bimonthly

16a. AG's Office
b. Police
c. Courts
d. Medical Examiner
e. Hospitals

18. March of Dimes
b. Brown University
c. Developmental Disabilities Unit, RI Hospital
d. Universal Affiliated Programs
e. Family Voices
f. DCYF
g. DHS

19. Media
b. Business people
c. Policymakers
d. City of Pawtucket

21. *DHS (especially related to Rite Care, adol. Preg prev program)
b. *DOE
c. DCYF
d. Professional Associations (Provider Organizations)
e. Libraries
f. CBO's especially minority based
g. Community Health Centers

24. Occupational Nurses
b. Hospitals
c. Councils
d. Other places of employment

25. 10-11 companies providing interfacility transfers (e.g. private ambulance association of RI)
b. Hospitals
c. RI Association of Fire Chiefs
d. New England Council for Emergency Medical Services
e. National Highway and Safety Administration

f. Governor's Office on Highway Safety
g. RI EMS Instructors Association
h. Hospital Association- bi-monthly
i. National Association of State EMS Directors
j. National Council of State EMS Training Coordinators

26a. Family Health- Early Intervention
b. Family Health- Lead Program
c. Family Health-Immunizations program
d. Family Health- KIDS Net
e.Community-Based Organizations
f. Rite Care
g. International Institute
h. Genesis

10. How often do you interact with these groups?
All ongoing unless otherwise specified

11. Please briefly describe the nature of this collaboration including any events or policy issues you plan or work on together?

1. See #4

2. Loan repayment
   Provider education
   Technical Assistance

3. See #4

4a. Smoke-free restaurants and public places
b. Preventing youth access to tobacco
c. quit smoking events
d. Tobacco control awareness days (i.e. World No Tobacco Day, Kick Butts Day)

5a. Collaborations relate to legislative issues
b. Also, grant funding; trying to find community agencies who can benefit from CDC grants, etc.

6a. RiteCare Newsletter
b. Via REACH
c. Inner Circle; youth at risk; brochure for superintendents with recommendations
d. Participate on planning and steering committees to share expertise (i.e. DSA is on the ENCORE committee)

7a-h Access to high quality, comprehensive, coordinated, community responsive primary care and oral health services for vulnerable underserved populations statewide are key policy issues for all collaborations listed above.

f. Interdisciplinary primary care training program for health professions students supported by the NHSC, in collaboration with the Department of Family Medicine, Memorial Hospital (MHRI) and the RI Department of Health (HEALTH). Matches medical, dental, advanced practice nursing, and mental health/behavioral health students with preceptors/mentors in community-based agencies that work with vulnerable and underserved populations statewide. [Provides potential opportunity for violence prevention education as part of the SEARCH Program didactic component].

8a. Dr. Hollinshead is on the Pediatric staff
b. Data Development
c. School based activities
d. Pregnancy outcomes
f. Foster care issues
g. Focus on cabinet goals; teen preg, HSHK, starting right
h. RiteCare, Welfare

9a. Teen Pregnancy planning (DOE, HHS, DCYF)
b. After school programming, starting right
g. Collaborate with core areas
j. Under age drinking initiative

10. To improve quality of health care services
b. To revise/adopt/delete regulations
c. To develop communications tools (inter-agency forms)
d. To develop training programs
e. Regarding employee/personnel issues

11a. Health presence (to build relationship)
b. Early Childhood issues
c. Ongoing advocacy related to tobacco control and screening
d. West Nile Virus issues
e. Legislative issues related to physicians
f. School Health
g. Legislative issues
h. Injury prevention/pedestrian safety
i. Pedestrian safety

13a. Pertaining to regulatory functions
b. Education about environmental lead
c. Same as B
d. Regarding regulatory functions

14a. Traffic Safety; data collection
b. Youth Survey (2 including the Adolescent Substance Abuse Survey)
c. Medicaid Managed Care Research and Evaluation team
d. Provide information to, from time to time
e. Obtain HDD

15a. Determines if a legal investigation is needed regarding a death. If so, alerts Attorney General's office
b. Provides information to DOT regarding deaths involving motor vehicles
c. Provides DOH divisions that request it, cause of death forms. Also, Medical Examiner signs death certificates that are filed with the DOH.
d. Collaborate on Child Death Review with Dr. Jennie.

16 A-C: The forensic lab examines evidence in criminal cases and reports its findings to the criminal justice system in the form of written reports and testimony. This includes, the AG, courts, police, etc..
d. The forensic lab staff examines samples obtained at autopsy to help uncover the cause of death
e. Training is provided to hospital staff regarding how to collect samples from rape victims.

18f. Surrogate parent program/ advocating for kids to get medicaid/medicare, education, encouragement
Developmental disabilities unit, rehab servicing, quality assurance

19a-c. These groups are contacted regarding health communication, policy, and community affairs
d. Quarterly meetings to link municipalities with HEALTH

21a-c. Adolescent media campaign
d. Vasectomy campaign
e. COZs
f. Various other campaigns

24. All in relation to improved worksite health

25a. licensure/standards
b. communication, quality assurance, protocols
c. administrative items, questions, regulations
d. 6 states apart of this; deal with transports across borders, reciprocity, etc.
e. federal curricula for EMS training
f. seatbelt use, etc.
g, i. EMS Training and licensing
j. EMS System Development

26 a-c data analysis; comparing rates of lead screening, immunization among WIC population
d. Pilot project
e. Outreach
f. Referrals, training
g-h Training regarding WIC program

12. What resources other than your participation do you provide to this (these) group(s)? (i.e. publications, training, technical assistance, training, data analysis, etc.)

4. Training, technical assistance, data analysis sometimes

5. Human resources provided/ connections/ networking/ resource development

6. Networking opportunities,Training, TA, collaboration on events, committees

7. Training, technical assistance, data analysis, continuing education

8. Data and evaluation unit provides information to KIDS Count

9. Training, technical assistance

10. In-service education/training, consultation (e.g. abuse prohibition-see attachment)

11. Public Health presence and perspective; public health information, sometimes data

13. Education, technical assistance

18. Education, advocacy

19. Health information

21. Technical Assistance on media relations; special events, communication, publications

24. Training on how to incorporate wellness strategies into the worksite

25. Train EMT instructors via New England Training guidelines

13. Would violence prevention messages be relevant to these groups or their constituencies? If so, which ones?

Yes	No
5. probably all, 6 (most definitely), 8,9 10 (however, all facilities are mandated by law to follow regulations related to abuse prohibition, but more training needed for personnel.) 11, 13. Maybe related to OSHA; 14, 18, 19,21, 24 (probably would be important as employers are putting together their wellness plans) 25 (any of these may be relevant; EMS is becoming increasingly more prevention oriented and community-based), 26	4 (not sure); 7 (possibly)

14. What coalitions are you a part of?

1. Worked in the past with the *RIAVC on legislation related to gun control
b. *Breast Cancer Coalition

3. Women's Cancer Screening, Region 1 Women's Health, Women's Commission, Oral Health Steering Committee, Primary Care Physicians Advisory Committee, School based Health Center Commission, ProfEd-Diabetes, Rural Health Round Table, State Professional Loan Repayment Board, Homeless Commission on Housing. Indigent Drug Program, Brown University Medical School Affinity Group

4a. *RI cancer control coalition
b. *Tobacco Control Coalition

5. Aging 2000- private non-profit; Frank is on the Board- ongoing

6a. RI HIV Community Planning Group
6b. HIV Prevention Educators (vendors)- monthly
c. Youth Connection (Urban League)- monthly

7a. HSHK! Oral Health Initiative for School Aged Children- Quarterly
b. HS! HK! Ad Hoc Workgroups - Monthly meetings or as needed
c. HEALTH Oral Health Coordinating Team (Interdepartmental) – As needed.
d. RIDHS Dental Advisory Committee – As scheduled by RIDHS

8. Immunizations
8b. Hunger
c. Elmwood Action
d. *COZs
e. Professional Coalitions
f. Grassroots coalitions

g. Men to Be
h. Early Childhood Coalition

9. Included in Q9

10. Included in Q10

11. Healthy Mothers/Healthy Babies

13. Minority Health Advisory Committee (a DOH group with community involvement)

14. Minority Health Advisory Committee

18a.RI Women's Coalition- ongoing
b. Interagency Coordinating council- ongoing

24. None (other than worksite wellness council that she is the liaison to)

25a. Safe Kids/Safe Communities
b. RI Traffic Safety Coalition

26. Cultural Coalition

15. How often do you interact with these groups?

Ongoing unless otherwise specified

16. Please describe the nature of your involvement in these groups, including any events or policy issues you work on together?

4. a. Media advocacy (last year: op-ed pieces, letters to the editor, campaigns (TV, radio billboards)) This year, print ads;
b. Hired two media consultants targeting non-traditional groups

5a. This group supports the development of publications for the elderly re insurance options
b. Education to the Elderly
c. Education of health care providers about the elderly and dealing with this population
d. Finding gaps in services

6. This group oversees the implementation of a comprehensive plan for HIV prevention in RI
b. HIV prevention programs throughout the state
c. Collaborate of youth service providers

7a. Steering Committee, in collaboration with Oral Health Staff Team, seeks to advance recommendations developed to improve the oral health of school-aged children using school-based/school-linked oral health programs.

b. Three ad hoc workgroups (Finance & Service Delivery Workgroup; School-based Services & Data Collection Workgroup; Community & Family Outreach Workgroup) develop strategies to effectively implement Steering Committee recommendations.
c. Interdepartmental group that advises the Director of Health on effective oral public health policies, programs, and practices designed to favorably impact the oral health status of the Rhode Island population and makes recommendations related to oral public health assessment, policy development, and assurance
d. Advisory Committee convened to address access to oral health care issues for RIte Care and Medicaid populations.

8. Lead, community safety, etc (need to ask specific program people)

12. Becky Bessette is the contact person;

14. Work on issues related to minority health

17a. This group includes representatives from CBO's, provider organizations, and racial and ethnic advocacy groups in the State. This group provides advice to the Office of Minority Health.

18b. This group advises the Dept of Health and the Special Needs Program

25a. Advocacy- Helmets, seatbelts, car seats, safe playgrounds, etc.
b. Advocacy- Helmets, seatbelts, 0.8 legislation, data collection

26. Training around better outreach, particularly among immigrants; policy issues

17. What resources other than participation do you provide to this (these) group(s)? (i.e. publications, training, technical assistance, training, data analysis, etc.)

4. Materials, setting up events, planning/buying media

5. Participation in education subcommittee

7. Training, Technical Assistance, data analysis, data collection

8. Policy analysis

25. Data from RI Emergency Run Reports
Publications as part of DOH databook

18. Would violence prevention messages be relevant to these groups or their constituencies? If so, which ones? (Place a check next to each one in #16 above)

Yes	No
1, 4, 5, 6, 7 Yes- school oral health professionals, School Nurse Teachers; 8, 10, 14, 18, 25, 26	

WORKING GROUPS

19.Are you a part of any work groups within the health department? If so, which ones

4a. Diabetes public education group- meets monthly
b. Ad Hoc Communications Committee- meets monthly
c. Surveillance Team- meets weekly

5a. Executive committee

6a. Surveillance Group (communicable diseases)- meets on Mondays
b. Materials Review

9. Communications group- once a month
b. Data subgroup- once/month
c. Starting right- as needed
d. Data team, Male involvement team, PR team- once/mo

10. Bill Waters group
10b.AG/Hospital Association

13. Safety and Health Committee- monthly
b.Worksite Health Committee- monthly

14a. Janna is a part of the Surveillance and Evaluation group – once a week
b. Health Care Quality - once/mo

21. Worksite Wellness- Quarterly

24. Worksite wellness group at DOH- Quarterly

26a. Oral Health Steering committee- Monthly
b. Breast Feeding Taskforce- Monthly
c.Obesity Task Force- Monthly
d. Hunger group- Monthly

20. How often does this group(s) meet?

21. Please describe the activities or purpose of this (these) group(s).

4a. Diabetes media efforts
b. communication issues, DOH

c. Varies, technical input on surveillance and evaluation issues

5. Approves policies, makes decisions for the Department

6a. To discuss surveillance issues
b.To make sure materials meet federal guidelines

10. To discuss staffing shortages, etc
10b. To discuss latex allergies, etc.

13a. Develops internal policies for the health dept.
13b. plans fairs, presentations, etc. related to employee health

14. Review of survey information, data etc..

21. Referred to Edna Poulin (see #24)

24. This group comes together to discuss how DOH can become active in worksite wellness. If we are going to advise other people how to improve worksite wellness, we need to do practice what we preach, so to speak.

26 a-d .To discuss issues around these respective topics

INTERNET RESOURCES

22. Does your program have a web site?

Yes	No
2, 3, 4,6,8,10, 17, 18, 24	7 (in development),9,11,13, 14 (in development), 15, 16, 19,21, 25 in development, 26

*Note: Worksite Wellness of RI has a site on the HEALTH web site

a. If so, would you be willing to make a link from your site to the violence prevention program web site?

Yes	No
2, 3, 4 (need to discuss with staff) 6,8,10, 14 Yes, if we had some data that they could link to; 24 (if there was something specific to worksite health geared towards employers)	

Note: 7, 25 (willing to make link when web site is completed)

23. Do any of the organizations you work with have web sites that you know of?

Yes	No/DK
1, 3, 4, 7,8,11, 14, 24	2, 6,9,10,16,18, 19, 21, 25, 26

a. Which ones?

1. American Cancer Society,
American Heart Association
American Lung Association
Managed Care groups

3. American Lung Association

4. American Lung Association (local)

7.RIDA
MHRI

8. Kids Count, Dept of Ed, Hasbro

11. Probably all (City of Pawtucket, City of Providence, Cancer Society, DEM, RI Medical Society, Dept of Education, Governor's Policy Office, Governor's Highway Safety Office, DOT

14. DHS, DOT, DOE

24. Welcoa, local wellness council

b. Do you think any of these groups would be interested in setting up links to the VPP?

Yes	No, NA, DK
1, 11	4, 5, 6, 8, 9

c. If so, which ones? (Circle above)

1. United Health Care in particular since they've sponsored some violence prevention activities in the past
11. Would have to ask

OTHER RESOURCES (DATA, STAFF, TECHNICAL ASSISTANCE, FUNDING)

24. In what other ways do you interact or reach out to your constituencies?

4. Materials, monthly or 6 week meetings, trainings/technical assistance, satellite broadcasts

6. We spend a lot of time with our vendors through TA and training, site visits, collaborative meetings and capcity building support

10. staff within facilities regs go from facility to facility doing inspections and investigating complaints. They directly observe the facilities and work with them to improve quality of care.

11. By having a personal presence; meeting with people

13. Attend and participate in different seminars and trainings

14. Analyze death certificates, HDD, and surveys that may be of interest to VPP

16. Forensic sciences unit advocates for legislation related to improving technologies that will help in forensic investigations.

26. Hold focus groups with staff, providers, agencies, and clients
Public education

25. What (other) resources do you have that (could) directly or indirectly impact violence prevention or its associated risk factors?

2. Professional community interfaces with OPC through our programs. Key physician, nurse practitioner, dental and community based providers that provide primary health care to uninsured populations statewide.

3. Tobacco control program is hiring 4 minority coordinators who will be assigned to the Urban League, Progresso Latino, Indian Council, and SEDC. These people will be holding focus groups with their respective minority communities. It's possible that they could add violence prevention questions in their focus groups or let us ask our own questions of these groups. This won't be happening until next fall most likely.

Also, Carol Hall-Walker has a lot of knowledge on media and could provide technical assistance on how to write press releases, who to call, etc.. Media consultants just hired who will provide information on working with corporate partners. It's possible we could also tap into this as a resource.

11. The mayor of Pawtucket might be willing to do a press release if we had something solid to say

14. Gunshot wounds database

19. We have some HEALTH staff who can help with graphics and the creation of communication materials

25. RI EMS Ambulance Run Report- reports on trauma, demographics, age, sex, etc.

26. 100 local agency staff; site visit possibly

OTHER CONTACTS (SEE PAGE 26)

Appendix D
Department of Health- Other Comments

The following comments, suggestions, and observations were also made by respondents. These comments are in no particular order.

1) Within the health department, BRFSS data and Kidsnet data would be a good resource.

2) Another suggestion, to combine the Breast Cancer Awareness Month with Domestic Violence Awareness Month.

3) Regarding inclusion of violence prevention messages in other program materials: There may be some resistance in some of the programs. Philosophically, they all should consider this, but in reality some people may be of the mindset that this "isn't my issue."

4) Violence is an issue that impacts all people. Programs that impact women, the elderly, youth, etc. have a natural connection.

5) Messages need to be tailored and be kept subtle as the word 'violence' in and of itself is not a pretty word.

6) The idea of including violence messages within other programs' brochures etc. is "revolutionary" but may receive mixed support.

7) The challenge of resources within the realm of the categorical grant is one that we all grapple with. In the Office of Primary Care, two of the largest grants receive funding from the CDC. The smaller grants from the federal BPHC, Rural Health, Oral Health and the National Health Service Corps Programs have opportunities that would create networking with key constituents. The coordination of these efforts would require the most important component to moving an agenda forward, the human resource that could champion this important effort.

8) Lots of groups are looking for short 1-2 hr trainings i.e. DOC and the Training School

9) Gay/Lesbian Youth are at-risk and need support

10) In the future, violence prevention information might be included in the annual manual for NHSC SEARCH participants and/or continuing education opportunities for oral health professionals.

11) Look at PANDA information (Prevent Abuse and Neglect through Dental Awareness)

12) There are coalitions in the 5 core areas of RI funded through the Office of Juvenile Justice and Delinquency Prevention that the VPP may be interested in.

13) Office of the Medical Examiner procedure: Referral from Hospital, Police etc. to Medical Examiner of any unexpected deaths, all injuries, some hospital deaths, and all deaths of

children under 18--→ Case review to see if examination needed→If so, autopsy done and investigation of circumstances of death determined and report written→ appropriate person/agency notified (AG, DOT etc)→ funeral home provided a signed death certificate→ funeral home adds some information to it→ death certificate filed at HEALTH.

14) The Violence Prevention Program does not currently receive "cause of death reports" from the Medical Examiner's office but these reports can be requested.

15) No computerization of medical examiner files and no reporting of information to the public. Only certain people allowed access to data. Cause of death can be reported to the public but the circumstances cannot.

16) Rhode Island Hospital does child fatality review. This could be very useful information to the VPP, however, this data is not published for public use, and again access is very limited.

17) 700 autopsies done per year. The age range of the deaths autopsied reflect the population but is skewed a bit more toward young people. Anecdotally, suicides are increasing.

18) 4-5,000 cases per year for drug testing; about 750 autopsies; about 300 sexual assaults, and about 100 other violent crime examinations. Cases about stable but more work being done for each. Cases from medical examiner increased about 20-25% over past few years. Need for additional capacity in the area of forensic DNA.

19) Early Intervention Program identifies children at-risk and has a whole set of means by which to provide support for these kids and their families. This system also feeds into KIDS NET and into DCYF's Comprehensive Emergency Services.

20) The Interagency Coordinating Council is the place where the VPP might have an in-road. DCYF is the obvious link if we are interested in interagency collaborations. MHRH and DOC are also important players as well.

21) There is a lot to do to advocate for children and families.

22) Childhood trauma can be the result of violence.

23) We should try and change policies around violence vs. trying to tackle individual behavior

24) Violence is in the top 5 priorities for groups like the media, business, and policymakers. Everyone is interested. It's not necessary therefore to mobilize these groups only to capitalize on their interest.

25) A lot of people are not ready to talk about violence

26) Suggestion to look at Family Health needs assessment to see where violence issues rank.

27) Violence in the community and in schools is considered a problem/concern by parents as determined by parent consultants.

28) Due to the uncontrolled environment of prehospital emergency practice, there are many occasions where prudent action by the EMT is necessary to avoid altercation or conflict. This may be due to impaired patients, emotional patients and families or bystanders. Many behavioral issues are involved in this environment.

29) MAP is looking for DV, victim and perpetrator workshops and staff training. Must be able to relate to substance use clients.

Appendix E
Department of Education Individual Responses

The following information was obtained from each of three interviews with people at the Rhode Island Department of Education involved in Healthy Schools! Healthy Kids! and violence prevention. As mentioned in the methods section of the executive summary, these interviews were open ended and provided a means of information and resource gathering.

Interview #1

- The Department of Education and HSHK houses a resource center. This center includes books, articles, and videos on health topics, including violence prevention as well a computer with internet access. Health education curricula for each school district are also located here. These curricula may serve as a resource for the VPP, however, many of them are not currently up to date. All schools will be asked to submit updated versions of their health education curriculum by the end of the summer 2000. The HSHK resource center can be accessed at http://www.ri.net/RIDE/health/Bibliography/toc.html.

- Each school district is charged with creating a health education curriculum that incorporates the health education standards (**See Appendix G**) and meets the desired outcomes. However, each school is free to develop the curriculum in whatever way it sees fit. In some instances, individual schools take it upon themselves to create this curriculum.

- Statewide health education assessments takes place at grades 5 and 9.

- Another resource within the Department of Education is Information Works!, a publication with an accompanying web site. This resource lists each school and its performance measures including the numbers of suspensions. While this suspension category is not broken down into more meaningful categories it may be interesting to compare suspension rates across schools and school districts to get a sense of the rate of this practice. Access Information Works! at http://www.infoworks.ride.uri.edu .

Interview #2

- Two areas related to sexuality education and violence are sexual abuse and date rape.

- The Department of Education works with all the schools and with community based agencies that have sexuality education as part of its focus. Some of these agencies include: John Hope Settlement House, The Urban League, etc.. These agencies would be interested in violence prevention messages.

- The risk of violence in RI schools is less than in other states.

- Two other sources of information about the status of RI schools can be obtained from the SALT survey and from talking to parents and teachers.

- Other referrals: George McDonough who is the Coordinator for the Safe and Drug Free Schools Program and to Bill Eyman who is interested in helping schools become more holistic.

Interview #3

- The Student Discipline Record System is one resource for tracking violence in RI public schools. This report breaks down infractions by school and district, age, grade, race/ethnicity, etc.

- It is possible to overlay what prevention programs are available in particular areas and where there are the most suspensions for violence etc. From there, it is possible to see if there is any correlation between the two.

- The Student Discipline Record System is composed of 12 categories of infractions, 11 of which are due to safety and danger, including violence-related events. Infractions due to these 11 categories compose 24% of all infractions.

- The Student Discipline Record System has been in effect for 4 years. Over the course of one year the number of infractions jumped by 10,000. All of these infractions were categorized in the 12th category, "other" which includes things such as being late for or skipping class.

- Another source of information is the SALT survey. This information is accessible on the web at http://www.infoworks.ride.uri.edu/2000/salt.htm and provides information about public schools in Rhode Island including suspension rates.

- Another resource within the Department of Education is the Safe and Drug Free Schools (SDFS) Program: Every state receives money for SDFS programming. Twenty percent of the money goes to MHRH and 80% goes to DOE. Of the 80%, 91% goes to schools. Of this 91%, 70% is allocated to districts based on enrollment size and 30% is allocated to schools based on need. These latter schools are Providence, Pawtucket, Central Falls, Woonsocket, and Newport. In 1999, one-third of the SFDS money ended up in Providence in the Student Assistance Program (SAP) program. Other communities also have SAP programs, but not all of these are funded by SDFS. Other SDFS money is used for specific programs.

- The goals of SFDS, the common core of education, goals 2000, and the comprehensive education strategy all build on one another. Prevention is part and parcel of these efforts and particularly within SFDS which has the goal of building resiliency.

- The annual SFDS report is shared with the legislature.

- The Youth Risk Behavior Survey (YRBS) is another resource but local school districts do not find it very helpful as the results are state-wide and not broken down locally.

Appendix F
Healthy Rhode Islanders 2000
Violence Objectives

Reduce suicides and inurious suicide attempts by:

- **Reducing suicide by 10% to no more than 9.2 per 100,000 people**
- **Reducing the incidence of suicide attempts which lead to hospitalization by 15%**

Reduce homicides and assault injuries by:

- **Reducing homicides by 15% to no more than 2.4 per 100,000 people**
- **Reducing assault injuries leading to hospitalization by 10% to no more than 36.9 per 100,000 people**

Appendix G

RHODE ISLAND'S HEALTH EDUCATION STANDARDS

Standard One

Students will understand the concepts related to health promotion and disease prevention as a foundation for a healthy life.

Standard Two

Students will demonstrate the ability to access valid health information and health-promoting products and services.

Standard Three

Students will demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

Standard Four

Students will analyze the influence of culture, media, technology and other factors on health.

Standard Five

Students will demonstrate the ability to use interpersonal communication skills to enhance health.

Standard Six

Students will demonstrate the ability to use goal setting and decision-making to enhance health.

Standard Seven

Students will demonstrate the ability to advocate for personal, family, community and environmental health.

Appendix H
Spectrum of Prevention

Influencing Policy and Legislation
Changing Organizational Practices
Fostering Coalitions and Networks
Educating Providers
Promoting Community Education
Strengthening Individual Knowledge and Skills

References

Cohen, L. and Swift, S. A Public Health Approach to the Violence Epidemic in the United States. *Environment and Urbanization*. 1993 5(2):50-66.

Mercy, J.A., Rosenberg, M.L., Powell, K.E., Broome, C.V., and Roper, W.L. Public Health Policy for Preventing Violence. Health Affairs. Winter 1993: 8-27.